TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ADEWALE ADENIRAN MD

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-17-0371-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 1/22/16 Sedgwick issued authorization #1919XXX for a lumbar discectomy. All other claims before and after the date of surgery were billed... and have been paid by Sedgwick."

Amount in Dispute: $4,430.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In addition to raising preauthorization, the EOBs raise underlying issues of causal relation. Note the reconsideration EOB dated in May. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions denied and not related to the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
March 18, 2106	63030-Lumbar Laminotomy	$4,430.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - W3-Additional payment made on appeal/reconsideration
   - 193- Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor bill for the service that was preauthorized by the insurance carrier?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT code 63030 rendered on March 18, 2016. The insurance carrier's position summary states in pertinent part, "In addition to raising preauthorization, the EOBs raise underlying issues of causal relation. Note the reconsideration EOB date in May. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions denied and not related to the compensable injury." Review of the documentation presented by the insurance carrier finds that the documentation does not contain copies of EOBs. Review of the documentation presented by the requestor contains three (3) copies of EOBs. Review of the submitted documentation finds the following:

   EOB dated received by the vendor on April 21, 2016 contains the following denial reason code(s):

   - 197 – Payment denied/reduced for absence of precertification/authorization.

   EOB dated received by the vendor on May 25, 2016 contains the following denial reason code(s):

   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - W3-Additional payment made on appeal/reconsideration.

   EOB dated received by the vendor on September 27, 2016 contains the following denial reason code(s):

   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 193- Original payment decision is being maintained. This claim was processed properly the first time.
   - W3-Additional payment made on appeal/reconsideration.

   To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e), (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury:

   31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified: Former 133.240(e), (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury. The Division finds that none of the EOBs presented for review contain information/documentation to support that the insurance carrier raised the issue of underlying causal relation as indicated by the insurance carrier during the bill review process. In addition, 28 Texas Administrative Code §133.307 (d) (2) (F) states, in pertinent part, "(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review..."

   The Division finds that the defenses the carrier raised at medical fee dispute resolution are new defenses and cannot be considered in this review. The division therefore proceeds to resolve this dispute by adjudicating the payment under the applicable fee guideline.

2. The insurance carrier denied/reduced the disputed CPT Code 63030 with denial/reduction code "197 – Payment denied/reduced for absence of precertification/authorization."

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT Code 63030 defined by AMA CPT Code Book as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."

   Review of the submitted documentation which includes the preauthorization letter and the peer review letter, supports that the insurance carrier preauthorized a "Left L4-5 Discectomy." The requestor states in their position summary in pertinent part, "On 1/21/16 a Peer Review was performed by David Trotter, MD and advised a Left L4-5 discectomy was medically necessary."

   Review of the preauthorization letter dated January 22, 2016 issued by Sedgwick states the following: "Left L4-5 Discectomy/Medically Certified by Physician Advisor... The medical provider, injured worker and workers' compensation claims adjuster have been notified that this specific service meets established criteria for medical necessity ONLY based on the information presented by the medical provider." Additionally, the preauthorization letter indicates a start date of 1/22/16 and an end date of 3/31/2016.

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that preauthorization is required for the disputed surgery code 63030-lumbar laminotomy. The requestor obtained preauthorized for a discectomy, which has a different CPT Code assigned by the AMA CPT Code book. Pursuant to 28 Texas Administrative Code 134.600 (p), the requestor submitted insufficient documentation to support that the disputed lumbar laminotomy, CPT Code 63030 was preauthorized. As a result, the Division finds that the insurance carrier's denial of "197 – Payment denied/reduced for absence of precertification/authorization" is supported. Therefore, reimbursement cannot be recommended for CPT Code 63030 rendered on March 18, 2016.

3. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed service. As a result, reimbursement cannot be recommended for the disputed service.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

Authorized Signature

		November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si préfère hablar con una persona en español acerca d'ésta correspondencia, favor de llamar a 512-804-4812.